The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 1370
INTRODUCER:	Health Policy Committee and Senator Grimsley
SUBJECT:	Medicaid Provider Overpayments
DATE:	February 16, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	LLoyd	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Pre-meeting**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1370 authorizes the Agency for Health Care Administration (AHCA) to certify that a Medicaid provider is "out of business" and that any overpayments made to that provider cannot be collected. Such an authorization allows Florida to use a federal exemption from repayment of the mandatory Medicaid federal share for provider overpayments.

The bill removes obsolete technology references to expand the types of tools available to the AHCA to curb fraud and Medicaid overpayments.

The bill has a potentially positive fiscal impact to the state.

The bill provides an effective date of July 1, 2016.

II. Present Situation:

Florida Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare & Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the AHCA and financed with federal and state funds. Over 3.9 million Floridians are currently enrolled in Medicaid, and the program's estimated expenditures for the 2015-2016 fiscal year are over $24.9 billion.[1]

Medicaid provider agreements are voluntary contracts between the provider and the AHCA under s. 409.907, F.S., and specifies that a person or entity who enrolls in Medicaid as a provider agrees to comply with all laws, rules, and policies relating to the Medicaid program. Additionally, s. 409.907(4), F.S., specifically states:

> (4) A provider agreement shall provide that, if the provider sells or transfers a business interest or practice that substantially constitutes the entity named as the provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the provider in the provider agreement, the provider is required to maintain and make available to the agency Medicaid-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement.

Office of Medicaid Program Integrity

The Office of Medicaid Program Integrity (MPI), a unit within the Office of the Inspector General at AHCA, audits Medicaid providers and determines if an overpayment has occurred requiring a provider to return funds to the Medicaid program. The AHCA also works jointly with the Medicaid Fraud Control Unit (MFCU) of the Department of Legal Affairs to prevent, reduce, and mitigate health care fraud, waste, and abuse. Because audits are often retrospective in nature and completed on claims data that may be two to five years old, the Medicaid provider may have gone out of business, moved, or may not otherwise be able to be located when the audit has been completed.

The MPI is statutorily required to develop statistical methodologies to identify providers who exhibit aberrant billing patterns.[2] The MPI uses these methods to perform comprehensive audits and analyses of Medicaid providers. Overpayments identified through these audits are referred to the AHCA's Division of Operations, Bureau of Financial Services for collection.[3]

Any suspected criminal violation identified by the AHCA must be referred to the MFCU of the Office of the Attorney General for investigation.[4] The MFCU is responsible for investigating and prosecuting provider fraud within the Medicaid program which commonly involves fraud related to providers billing for services not provided, overcharging for services that are provided, or

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[1] Office of Economic and Demographic Research, *Social Services Estimating Conference* (Jan. 7, 2016) *available at* http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf (last visited Feb. 11, 2016).
[2] Section 409.913(2), F.S.
[3] Agency for Health Care Administration and the Department of Legal Affairs, *The State's Efforts to Control Medicaid Fraud and Fraud and Abuse FY 2014-2015*, p. 44 (December 15, 2015) *available at* https://ahca.myflorida.com/Executive/Inspector_General/docs/Medicaid_Fraud_Abuse_Annual_Reports/2014-15_MedicaidFraudandAbuseAnnualReport.pdf (last visited Feb. 5, 2016).
[4] Section 409.913(4), F.S.

billing for services that are medically unnecessary.[5] The AHCA and the MFCU are required to submit an annual joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year.[6]

When the AHCA discovers an overpayment has been made to a provider that has since gone out of business, a refund from the provider is still pursued, but, historically, less than one percent of such overpayment debts are recovered.[7]

Under federal law, the state is required to refund to federal CMS the federal share of the overpayment no later than one year after the state discovers that an overpayment has been made, regardless of whether the state has collected a refund from the provider.[8]

However, federal law provides that the requirement to refund the federal share to CMS can be waived in cases in which the state is unable to recover the overpayment because the provider has been determined bankrupt or out of business.[9] For an out-of-business provider, in order for the federal refund requirement to be waived, the state must, within one year of discovering the overpayment:

- Document its efforts to locate the provider and its assets; and
- Make available an affidavit or certification from the appropriate state legal authority establishing that the provider is out of business and that the overpayment cannot be collected under state law and procedures.[10]

Currently, the AHCA is not afforded a means under state law and procedures to certify that a Medicaid provider is out of business. Therefore, the provision for the federal refund requirement to be waived cannot be triggered. During Fiscal Year 2012-13, the AHCA was required to refund to CMS approximately $520,000, which represented the federal share of overpayments made to providers that had gone out of business. In Fiscal Year 2011-12, the sum was approximately $2.9 million.[11]

Home Health Care Services Monitoring Project

The Florida Medicaid program has implemented several programs to ensure its recipients do not receive unnecessary and inappropriate medical care and that providers bill for services actually provided. The AHCA manages a number of quality improvement and prior authorization projects to ensure that Medicaid recipients receive medically necessary, quality care in the most cost effective manner.[12] One of the Medicaid services subject to quality improvement or prior authorization is home health services. Sandata Technologies, LLC, currently verifies the

[5] *Supra* note 3, at 1.
[6] *Supra* note 3.
[7] Email from the Agency for Health Care Administration, Sept. 23, 2015, on file with staff of the Senate Appropriations Subcommittee on Health and Human Services.
[8] *See* 42 CFR 433.312(a)(2).
[9] *See* 42 CFR 433.312(b).
[10] *See* 42 CFR.433.318(d).
[11] *Supra*, note 7.
[12] Agency for Health Care Administration, *Utilization Review-Quality Assurance/Quality Improvement*, *http://ahca.myflorida.com/Medicaid/Utilization_Review/index.shtml* (last visited Feb. 9. 2016).

utilization and delivery of home health services through a telephone verification system using a technology called biometrics.[13] The databases contain information on home health agency staff, recipients, service authorizations, visit schedules, visit verifications, and billing activity.[14]

III. Effect of Proposed Changes:

Section 1 amends s. 409.908, F.S., to authorize the AHCA to certify a Medicaid provider as "out of business."

Section 2 amends s. 409.9132, F.S., to remove a reference to telephonic technology for the verification of home health service visits. This section authorizes the AHCA to use technology that is effective for identifying delivery of home health services and deterring fraudulent and abusive billing for the service. Alternate advanced technology may be available at this time.

Section 3 reenacts subsection (4) of s. 409.8132, F.S., relating to the Medikids program for the purposes of incorporating the changes to s. 409.908(25), F.S. This section is included as a cross-reference of Medicaid statutes that are also applicable to the Medikids program.

Section 4 provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under CS/SB 1370, Florida taxpayers will benefit from the retention of the state's federal share of Medicaid dollars.

[13] Id.
[14] Id.

Private vendors who provide technology that verify the delivery of home health visits may also benefit from the ability of the AHCA to use alternative methods of identifying and deterring fraud and abuse in the Medicaid program.

C. Government Sector Impact:

The AHCA estimates the bill would result in the anticipated average retention of $1 million to $3 million per state fiscal year in federal dollars to the state.[15]

Electronic verification for home health services was mandated to help curb fraud and abuse for these services. With the majority of Medicaid recipients receiving services through managed care plans, electronic visit verification has been reduced from being statewide to operating in eight counties where service utilization remains relatively high.[16] The AHCA will be able to procure a more effective form of an electronic visit verification system upon expiration of its current system with the modification under this bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.908 and 409.9132.

This bill reenacts section 409.8132 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on February 9, 2016:
The CS removes obsolete technology language which limits the AHCA's ability to use other technology to identify the delivery of home health services and deter fraudulent or abuse billing practices for these services.

[15] Id at 4.
[16] Agency for Health Care Administration, *Senate Bill 1370 Analysis* (Feb. 3, 2016) (on file with the Senate Committee on Health Policy).

B. Amendments:

None.